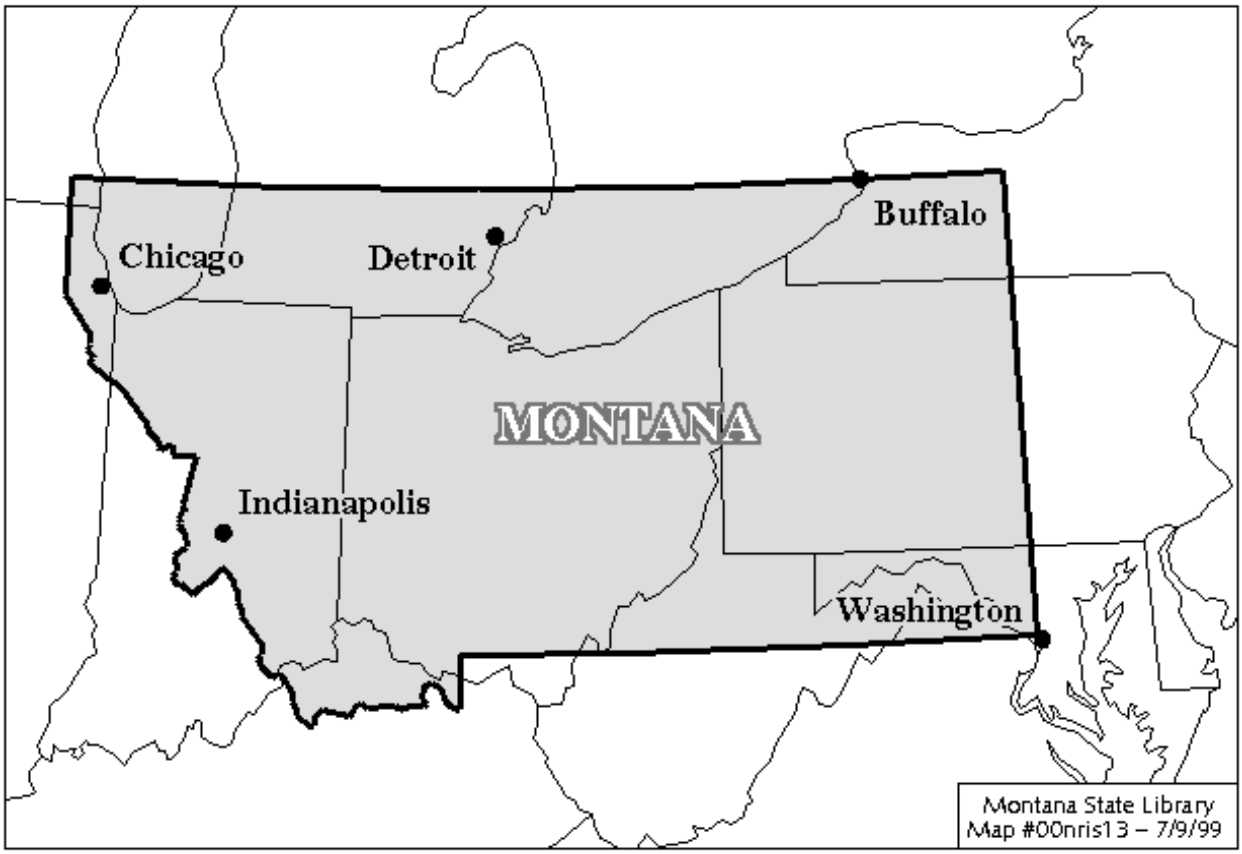
SECTION ONE
DESCRIPTION OF MENTAL HEALTH SYSTEM

Montana is known as "Big Sky Country" because of its vast size and rolling plains. The state covers a landmass of 145,552 square miles, has a population of 917,620 (2003 census), and a population density of 6.2 persons per square mile. To better demonstrate the vast size of Montana a map has been included in this section. In 2000, Montana had one of the lowest average annual wages ($24,264) in the nation, yet ranked third in the number of people holding multiple jobs. An estimated 15.5% of the population lives in poverty, including over 20% of the children in the state.



The population of Montana is predominately Caucasian (91%). The principal minority group in Montana is Native American (6.4%). Included within the boundaries of Montana are seven Indian reservations. Each is a distinct and sovereign nation, with a government, culture, and health systems that must be independently engaged and consulted. Poverty on the reservation is extreme, ranging from a low of 20% on the Flathead Reservation to a high of 39% on Fort Belknap. Unemployment rates range from 44% to 55%. The Indian Health Service provides behavioral and medical services for tribal members at 13 sites throughout Montana, both on the reservations and in the urban locations of Billings, Helena, Great Falls, and Butte. Other minority populations include Hispanic (2%), Asian or Pacific Islander (.6%), and African American (.3%). A quarter of the population is under the age of 18. Montana's population of persons over 64 is 13.4%.

The Montana Department of Public Health and Human Services (DPHHS) is the agency responsible for public mental health and chemical dependency services. The adult mental health system is in the Addictive and Mental Disorders Division. This division also administers three state-run facilities: the Montana State Hospital, the Montana Mental Health Nursing Care Center, and the Montana Chemical Dependency Center. The children's mental health system is under the Health Resources Division (HRD). In addition, HRD is responsible for Medicaid Primary Care services, and the Children's Health Insurance Program (CHIP).

Medicaid mental health services are provided to adults with severe disabling mental illness (SDMI) through a fee for service system that includes five licensed mental health centers, an estimated 550 private practitioners, 50 psychiatrists, other physicians, and five community hospitals with inpatient psychiatric beds. The state also administers the Mental Health Services Plan (MHSP) for adults with SDMI who are not eligible for Medicaid and have a family income that does not exceed 150% of the federal poverty level. MHSP services are contracted to four community mental health centers, and beneficiaries receive a limited pharmacy benefit of $425 per month toward the cost of medications for treatment of mental illness.

The Children Mental Health Bureau (CMHB) is responsible for management of children's mental health services and development of a system of care for youth mental health services. The mental health services have several funding sources: Medicaid, Children's Health Insurance Plan (CHIP) and the Children's Mental Health Service Plan (CMHSP). Children with serious emotional disturbance can access services by one of these plans. Each program has eligibility criteria and limits to their service array.

During the 2005 Legislative session the Montana Legislature changed the Medicaid eligibility resource test resulting in a projected additional 3000 youth who will be eligible. The Children's Health Insurance Plan (CHIP) began increasing its enrollment July 1, 2005. Additional funding, due in large part to the tobacco tax increase, allowed CHIP to cover an additional 3000 children above the current enrollment of 10,900. Although CHIP remains a capped service, providing a limited number of slots, this increase eliminated the entire CHIP waiting list. CMHSP income guidelines are set at 150% of poverty. One-hundred thirty-five youth are eligible for CMHSP-Part A if they are not eligible for Medicaid or CHIP.

Montana currently has four community mental health centers that provide outpatient services in all fifty-six counties. In addition to these community mental health centers, Montana has thirteen licensed mental health centers that serve youth and provide each of the core services as well as one or more of the services typically provided by a community mental health center. The Department contracts with six agencies to provide targeted youth case management. The providers are required to provide case management in identified service delivery areas.

The principle challenge to developing and maintaining human services programs in Montana is accessibility. Although concentrating services in larger areas would be the most efficient strategy for delivery, Montana has maintained an effort to provide mental health services in every county in the State. This accessibility provides for, at a minimum, identification of serious mental health problems, referral to more specialized services in larger communities, and supportive therapy and case management.

Because of the extreme rural nature of Montana, our entire plan is essentially a plan for delivery of mental health services in rural settings. For this reason, as will be further explained in "Descriptive Information" under ***Criterion 4,*** we have not identified specific objectives relating to rural issues. The entire plan addresses the manner in which mental health services will be provided to individuals residing in rural areas.

MENTAL HEALTH OVERSIGHT ADVISORY COUNCIL

The Mental Health Oversight Advisory Council (MHOAC) has provided valuable input to the Department over the past year. The mission of the Council is "Partners in planning for recovery based mental health system throughout Montana." The purpose of the Council as defined in state law (53-21-701(6)(a-d) is to:

- Provide input to the department in the development and management of any public mental health system.
- Provide a summary of each meeting and a copy of any recommendations made to the Department to the Legislative Finance committee and any other designated appropriate legislative interim committee.
- Fulfill any federal advisory council requirements in order to obtain federal funds for this program.

In addition to the defined responsibilities and mission above, the members of the Council agree that the role of the Council should include:

- Provide an ongoing forum for providers and consumers.
- Provide leadership and advocacy for the mental health system.
- Foster cooperative relationships among consumers, providers, the department, and other interested parties.
- Make specific recommendations to the department and the legislature.
- Provide input and advice in developing an effective system for delivering mental health services… don't reinvent the wheel; takes time to learn from other states.
- Encourage the department to clarify what it can and cannot do; to listen and respond to the needs and interests of consumers and providers; to clearly articulate its interests, priorities, and constraints.
- Monitor, evaluate and seek to continuously improve the system.

The Mental Health Oversight Advisory Council received technical assistance from the National Association of Planning and Advisory Councils. The Council expressed interest in expanding the Council representation to include Kids Management Authorities (KMA) and Service Area Authorities (SAA). In addition, the Council agreed to focus on three goals for the coming year. They are: establishment of local crisis services; to facilitate a better transition of inmates from the state prison who have a mental illness; and expansion of peer support services. The Council also held a work session to discuss the block grant and the new bylaws. This work session proved to be very productive for HRD, AMDD and the Council.

The Council and AMDD determined that to meet the intent of the federal and state statute the Council needed to be expanded from 21 members to 30 members. The request for expansion of the Council membership was sent to the Director of the Department and the Governor. At this time the Governor's staff was reviewing all Councils and boards of the state of Montana. Many of the Councils were deleted and/or were decreased in numbers of representation. However, the Governor approved the expansion. Request for Council members was advertised in all the major daily newspapers, sent out to SAA, Local Advisory Councils (LAC), and KMA, put on the Department and Governor's web sites, and sent to all advocates. The Governor's staff appointed the new members the end of July 2005 and the first meeting of the new Council was held in August 2005.

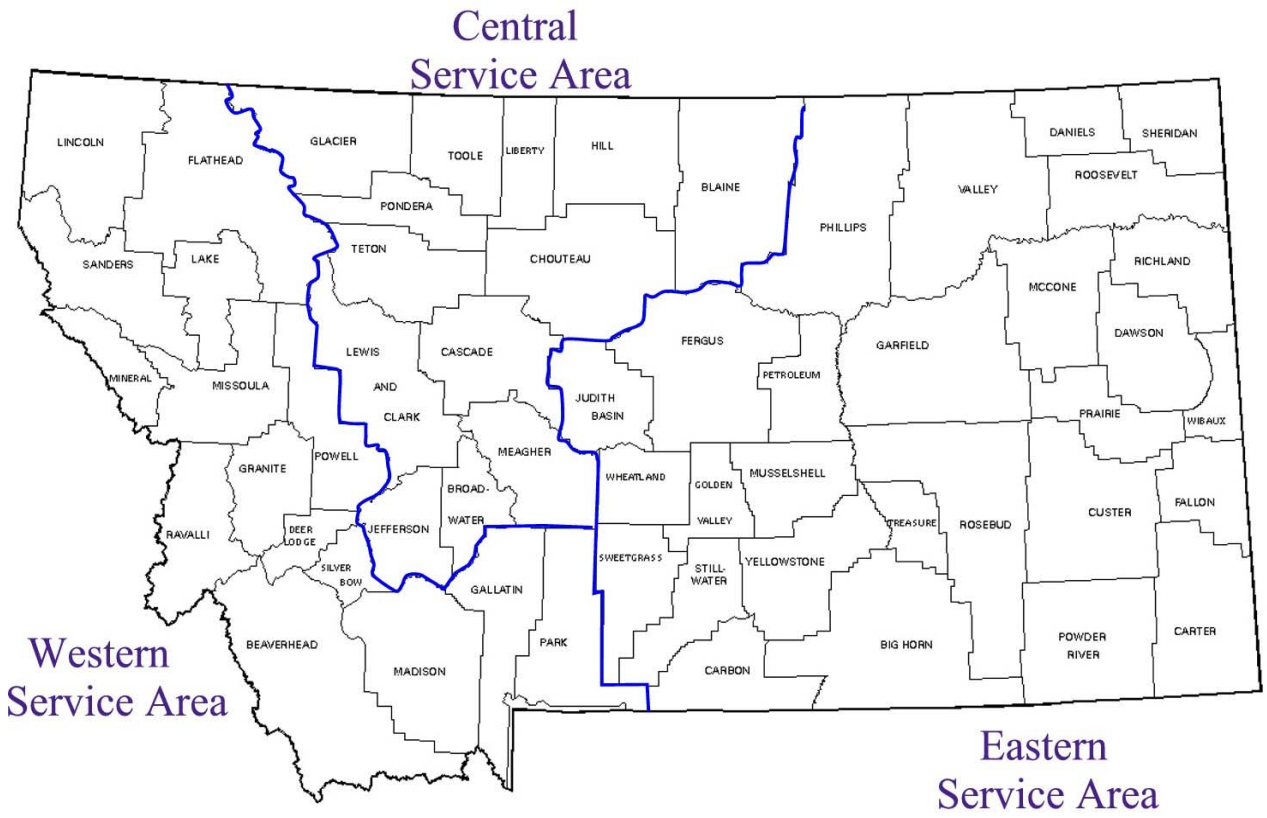
DEVELOPMENT OF SERVICE AREA AUTHORITIES

Service Area Authorities will allow local control of the public mental health system by stakeholders who can better decide how services should be delivered. Emphasis will be placed on achieving better consumer outcomes, increased performance on the part of service providers, and more cost-effective delivery patterns and processes. By dividing the state into three separate regions, communities within each region can better manage a system that meets the unique needs of the area.

The counties within each service area are as follows: (A map is below with the three service areas.)

1. **Western Service Area** consisting of Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, Ravalli, Granite, Powell, Deer Lodge, Silver Bow, Beaverhead and Madison counties.
2. **Central Service Area** consisting of Glacier, Toole, Liberty, Hill, Blaine, Pondera, Teton, Choteau, Lewis and Clark, Cascade, Jefferson, Broadwater, Meagher, Gallatin, and Park counties.
3. **Eastern Service Area** consisting of Phillips, Valley, Daniels, Sheridan, Roosevelt, Judith Basin, Fergus, Petroleum, Garfield, McCone, Richland, Dawson, Prairie, Wheatland, Golden Valley, Musselshell, Rosebud, Custer, Fallon, Sweetgrass, Stillwater, Yellowstone, Treasure, Carbon, Big Horn, Powder River, and Carter counties.

Service Areas



Restructuring the public mental health system in Montana has been no small task. Each SAA has filed for nonprofit corporation status and have leadership boards. The boards are 51% consumer and family member representation. The SAA and LAC development has taken over four years. The Department is requesting the SAA and LACs to actively participate in the development of the crisis response plan for Montana. AMDD held the first MetNet (televideo conferencing) with the SAAs and LACs to begin this discussion.

DEVELOPMENT OF KIDS MANAGEMENT AUTHORITIES

The KMA is the local community infrastructure that supports the comprehensive and statewide system of care. KMAs grew out of the Kids Integrated Delivery System (KIDS Project) that was developed and implemented by the Montana Children's Initiative Provider Association (MCI) in cooperation with the Department and the State Multi-agency Children's Committee. KMAs have two distinct and important functions. They are: community teams which are tasked with creating a process for a local system of care, identifying and creating ongoing community resources, developing policies and procedures to ensure comprehensive service delivery, and serving as the gateway to the local system; and Individual Care Coordination Teams which will design a unified and comprehensive treatment plan serving an individual family.

NEW INITIATIVES

In September 2004, the Department of Public Health and Human Services was awarded a SAMHSA grant. Montana teams have been delegates to SAMHSA sponsored trainings during this first grant year. A Request for Proposals has been let seeking applications for four communities to receive awards of up to $185,000 for a maximum five years. The communities selected will be responsible for creating infrastructure for this system of care and will be provided flexible spending dollars designed to keep youth in their homes and communities.

The Children's System of Care Committee (SOC's) ushered in a new approach to the delivery of services to youth with SED and their families. Created by the 2003 Legislature this advisory group continues to grow in its capacity to manage the emerging system of care, and provide leadership to local communities as Montana moves towards family & youth driven, community based mental health services. This new approach is guided by system values that include:

- Parent/Family participation is to be a part of all levels of the children's system of care from policy planning to participation in their child's treatment plan.
- The system is culturally competent requiring agencies, programs and services to be responsive to the needs and culture of the populations served.
- Providers, planning, policies, etc. focus on the strengths of the parents and family as contributors to treatment and recovery.
- "Top-Down-Bottom Up approach" in partnerships with local communities, including Tribes to design and develop the system of care.
- The system through partnerships with providers designs and delivers evidenced-based services to youth with SED and their families.
- Services for youth with SED will be co-occurring capable to ensure service delivery with an integrated focus on both mental health and chemical dependency treatment needs.

Representatives from the following entities comprise the Committee: Parents and Youth; Providers; Native Americans; Supreme Court (juvenile probation); Office of Public Instruction; Legislature; Mental Health Advocates/Ombudsman; Department of Corrections; Service Area Authority (SAA); Mental Health Oversight Advisory Council; Department of Public Health and Human Services (Children's Mental Health Bureau. Chemical Dependency Program, Child and Family Services Division Disability Services Program); and First Health Services of Montana.

The philosophy of the children's public mental health system is to provide services that respect the preferences and rights of youth and family members as well as accommodate the special needs and circumstances of both. Montana's public mental health system strives to provide a full range of mental health services to children and adolescents with priority on services to youth with serious emotional disturbance. To the greatest extent possible, services are offered in the least restrictive, most appropriate, community-based setting, preferably in the adolescent or child's home

The major initiatives for the AMDD are: designing a crisis response system; the SSI/SSDI

documentation training; co-occurring initiative; strengths based case management; housing projects; shelter plus care vouchers; DBT and ACT teams becoming stronger and more effective; pursuing a HIFA and Home and Community Base Waivers; strengthening the relationship with the SAAs and the division; developing peer support services; and utilizing the field staff.

The philosophy of the adult mental health system is to provide a system that is person centered and the focus of all services provided to the individual. All services available have the goal of recovery.

SECTION TWO
IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEM'S STRENGTHS, NEEDS AND PRIORITIES

Strengths and Weaknesses

The primary weaknesses of the public mental health system in Montana as identified by the Mental Health Oversight Advisory Council and adult mental health can be categorized as follows: crisis services; medically indigent services; access to services; children issues; peer support and services; criminal justice issues; education of mental illness; homelessness; housing; employment; suicide prevention; elderly; admission criteria to the Montana State Hospital; transition services; and cultural competence.

Some of the issues that Montana struggles with for youth include: a lack of clearly defined mechanisms for parental involvement, systems that fail to recognize and respond to early danger signs, inconsistent availability of community-based services, fragmented services, deficit-based views and a lack of cultural understanding.

Crisis Services

Montana has one of the highest, if not the highest, suicide rates in the nation for both adults and youth. Montana currently has some components of a crisis response system, in the form of crisis telephone lines, mobile teams in some parts of the state and some crisis houses available to individuals who voluntarily agree to stay. Most, if not all, communities have mental health professionals available to do assessments. There are inpatient psychiatric beds in only a few cities. While many general hospitals do their best to stabilize and care for consumers and families in crisis, they lack the expertise to treat consumers and families effectively. By default, hospital emergency rooms provide the entry point for adults requiring mental health crisis services. Services are not consistent across the state and all crisis houses lack secure rooms. This often results in mentally ill individuals being sent to the Montana State Hospital prior to a commitment hearing because the person is a danger to self or others and therefore, must be maintained in a secure setting.

The 2005 Legislature passed a Senate resolution to study crisis services in Montana. The Addictive and Mental Disorders Division will partner with the Mental Health Oversight Advisory Council (MHOAC), Service Area Authorities (SAA) and the Local Advisory Councils (LAC) to develop a plan for the next legislative session.

Medically Indigent Services

The medically indigent services are those services provided without a payment source. There are children who fall just above the Medicaid cut off and are not eligible for other services. A safety net is needed for those persons that have either a severe mental illness or serious emotional disturbance and do not qualify for any programs. An attached document demonstrates the enormity of this problem.

Transition Services

The transition of moving a youth with a serious emotional disturbance into the adult mental health system is rocky at best. The Transition Work Group consists of state level personnel from Developmental Disabilities Division, Adult Mental Health, Child and Family services, First Health Inc., of Montana, Early Head Start Collaboration, Court Services, Department of Corrections, and Tribal Nations. The Transition Work Group is tasked with developing smoother transitions from the various system of care.

Social Security

Social Security Insurance (SSI) and Social Security with Disability (SSDI) needs to have a faster turn around time. In one large community, it can take up to a year to become eligible. Without benefits, consumers and families cannot access medication and housing which is necessary for recovery.

The AMDD has been actively partnering with the Disability Determination Services to train psychologist and social workers from the MSH and case managers in the PATH programs on appropriate documentation. We have trained over 100 persons on SSI 101 and the importance of documentation. We also provided more intensive documentation training to case manager supervisors and PATH case managers in the fall of 2004. We have been chipping away at this crucial stumbling block for consumers to obtain benefits and be able to live in the community.

The Governor's Council on Homelessness has been selected as a participant in SSI/SSDI Outreach, Access, and Recovery (SOAR)Technical Assistance Initiative. The Planning team will have a facilitated action planning session in December. The result will be an action plan that is designed to increase access to SSI and SSDI for homeless people with disabilities, including those with serious disabling mental illness and/or co-occurring disorders. Two persons will be attending the Train-the-Trainer session in December. These trainers will then conduct trainings for case managers and particularly PATH case managers. The project will be collecting and reporting on outcome data which will assess the effectiveness of Montana's plan to increase access to SSA disability benefits.

Lack of Psychiatrists

One of the major needs in the adult mental health system is the lack of psychiatrists. Each mental health center has at least a three-month waiting list for psychiatrists. The mental health center in eastern Montana does not have a psychiatrist on staff. Advanced practice registered nurses (APRN) are used in lieu of psychiatrists. One mental health center refuses to use APRNs and rely heavily on their psychiatrists. The other mental health centers are utilizing APRNs to ease the burden on psychiatrists.

The psychiatrists received a provider rate increase July 1, 2005. It is hoped that this will encourage more psychiatrists to accept Medicaid and non-Medicaid clients. The AMDD will be tracking the number of psychiatrists to evaluate the outcome of the rate increase.

Peer Support Services

Another gap is the lack of peer support services. Mental health centers employ consumers in supportive employment, but Montana does not have consumer run services in Montana. This will be a priority in the next two years to develop peer run services and a method for reimbursement for the services. The Assertive Community Treatment (ACT) teams are investigating the possibility of including peer specialists on the team.
The Mental Health Oversight Advisory Council has requested technical assistance on models of peer support programs for adults as well as youth.

As one consumer so aptly said, "We need more programs for peer mentoring and support for independent living. When I am doing things for other people who are having trouble, my troubles don't seem to be so bad. I might be able to help myself while I am helping someone else."

The strengths of the mental health system in Montana are the providers, Mental Health Oversight Advisory Council, Systems of Care Grant and Committee, the relationship with NAMI-MT and Mental Health Association of Montana. The involvement of consumers and family members in the LAC, SAA, KMA and Council has proven to be invaluable. The relationships in Montana are what is forcing the mental health system to move forward.

GAPS

The gaps noted in Montana's children systems of care continuum were: meeting the need for training and technical support on a variety of issues; enhancing cultural competence; learning to braid categorical funding streams; bridging the chasms created by agency "lingo"; and institutionalizing the use of consistent evaluation and assessment tools. Finally, enhancing the working relationship between the state and local levels of the system of care is noted as a gap.

The adult mental health system has identified the lack of coordination of mental health services for the elderly; coordination with the American Indian population and reservations; and coordination with the veteran services on the state level as major chasms in the delivery system. These gaps have not been adequately addressed in the past.

VISION FOR THE FUTURE

Two major goals for Human Resources Division are: to implement the systems of care philosophy at the state and local levels; and plan for, develop and/or enhance a wraparound process that will enable children with serious emotional disturbance and their families to access a broad array of supports and services necessary to meet their unique needs.

Montana has a model in place for developing statewide infrastructure: the State Incentive Grant implemented the "Communities That Care" statewide. This project has received national attention for creating statewide prevention infrastructure. This model will be examined in building systems of care. Ultimately, the goal is to ensure better access to appropriate services for children and youth with SED and their families. In order to accommodate this, systems have

to be aligned and working cooperatively at numerous levels. This will be the biggest challenge for Montana.

In the future, consumers will be at the table making decisions at the policy level as well as at the individual treatment level. The mental health system will have alternatives of services available in the community. It is Montana's vision that one-day mental illness will be viewed and treated as any illness.